VSH Futures Project
Clinical Care Management Work Group
Stanley Hall, Waterbury State Office Complex
March 10, 2006
Minutes

Participants:

Sheryl Bellman, HCHS; Bob Pierattini, FAHC/UVM; Greg Miller, Retreat HealthCare; Tom Simpatico, VSH/UVM/FAHC; Richard Lanza, LCMH; Michael Sabourin, Advocate/NKHS; Bob Jimmerson, CSAC; Stuart Graves, WCMHS/NKHS; Sandy Steingard, HCHS; Bill McMains, VDH; Patti Barlow, VDH; Nick Emlen, VCDMHS; Michael Hartman, WCMHS; Scott Thompson, Advocate/LCMH; Linda Corey, VPS

Agenda

Update and Overview of the Futures Project
Discussion of CRT Council Work with VSH
Review of Care Management Protocols proposed to date
Discussion on how to develop protocols

Update and Overview of the Futures Project

Beth reviewed current activities in the project; architectural work, actuarial study, plan development for the Legislative Mental Health Oversight Committee, and issues regarding the siting of community residential recovery programs. She particularly expressed deep appreciation for the work that Cathy Rousse and Eric Grims of Northeast Kingdom Human Services did in attempting to develop a program in Greensboro.

Discussion of CRT Council Work with VSH

The CRT Council and VSH have been working to develop an approach to conveying clinical and social support information between the VSH and the community system. This has never been formalized and clinicians believe that if certain core information could be consistently conveyed, that it would assist positive transitions for CRT clients. This involved developing predictable information, conveyed in a consistent manner, to summarize client status and needs and to better match these with program capabilities.

Bob suggested that once this is developed, other hospitals could be included.

Review of Care Management Protocols proposed to date

The following protocols have been proposed for development. The group agrees that these protocols need to be written to apply to any client entering the system of care, not just CRT clients, for instance.

1. Crisis/emergency screening (not just for involuntary treatment)
2. Critieria for admission (for each level of care)
3. Census management
4. Determination of Safety and Need
5. Transportation
6. System-wide discharge planning for a person not connected to community services.
7. Payment for services for people with no insurance, or for care that is not covered by insurance.
8. Conflict resolution between entities
9. Client rights and dissemination of this information
10. Quality improvement for the care management system

Highlights of the discussions about these included:

- Each protocol should articulate standards for care with measures to assess whether or not the standard is met. Standards should also include timeframes for accessing care and client satisfaction / evaluation. Participants agreed that standards should reflect high quality care, even if these cannot be met currently. (For example, no one shall be discharged from the hospital without safe housing). These standards should exist, but they cannot be prescriptive.
- Each protocol should be considered from a perspective of how peers could be used to help support better outcomes for clients (for instance, peers may assist in communicating the impact of self neglect of medical conditions in a manner that is more powerful than can professionals).
- A consultation team for particularly challenging situations would be a terrific resource for the whole system.
- How we can better develop a concept of shared risk and shared support for difficult clinical situations.
- There are many clients who come into the acute care system who do not qualify for assistance such as case management – similarly, it is very difficult for people who are not CRT-eligible to gain access to psychiatry services. Sandy and the HCHS are developing a promising approach by developing long standing Psychiatric consultation services to primary care practices.

In addition, the group identified that it is time to develop options for how the care management system would be managed and staffed. Nick offered that the CRT council had developed a proposal for management and oversight. All agreed that it is time to review this.

The remainder of the meeting was devoted to clarifying work assignments and lead people.

Work Assignments

The key tasks are to draft the Protocols. Guidelines for drafting these are:

- The primary author will review all related existing protocols and assemble these into a single document
- The primary author will draft a new protocol designed to address all populations
- The primary author will suggest standards for care and measures to assess these standards
- The committee will review these and develop overarching approaches to format and content.
- **Patti Barlow will send to each lead author all materials that VDH identifies as being relevant.**

Lead authors are as follows:

1. Crisis/emergency screening (not just for involuntary treatment)
   (Sheryl Bellman)

2. Critieria for admission (for 3 inpatient levels – intensive, specialized and current DH; and for recovery residential)
   (**Tom Simpatico & Stuart Graves**)

3. Census management
   (**Tom Simpatico**)

4. Determination of Safety and Need
   (eliminated)

5. Transportation
   (**Anne Donahue – assigned in abstentia!, Patti Barlow and Charlie Biss**)

6. System-wide discharge planning for a person not connected to community services & consultation team process
   (**Sandy Steingard & Michael Hartman**)

7. Payment for services for people with no insurance, or for care that is not covered by insurance.
   (**Beth Tanzman**)

8. Conflict resolution between entities
   (**Bill McMains**)

9. Client rights and dissemination of this information
   (**Michael Sabourin**)

10. Quality improvement for the care management system
(**Greg Miller**)

Linda Corey will review all protocols for how peers could be utilized in implementation.

Nick Emlen will draft an overall management structure.

Next Meeting is April 28th, 9:00-11:00 Skylight Conference Room; Waterbury office complex.